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No. 94-1122

Supreme Court, U.S.
FILED
FEB 27 1995
OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1994

ST. FRANCIS MEDICAL CENTER, PETITIONER

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

1. Whether the court of appeals correctly held that the Provider Reimbursement Review Board lacked jurisdiction to hear petitioner's Medicare reimbursement claim arising from its 1985 fiscal year cost report because that claim did not meet the $10,000 amount in controversy requirement.

2. Whether the court of appeals correctly held that Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), precludes general federal question jurisdiction over petitioner's Medicare reimbursement claim.

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BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The opinions of the court of appeals (Pet. App. A1-A20, A21-A38) are reported at 962 F.2d 1110 (*St. Francis I*) and 32 F.3d 805 (*St. Francis II*).[1] The orders of the district court (Pet. App. A39, A52, A55) are unreported.

[1] Petitioner seeks review of two decisions of the court of appeals which arose from the same cause of action in federal district court, and which both involve the same Medicare reimbursement dispute. This Court has jurisdiction to review both decisions, see *Mercer* v. *Theriot*, 377 U.S. 152, 153 (1964).

JURISDICTION

The judgment of the court of appeals (Pet. App. A72-A73) in *St. Francis II* was entered on August 9, 1994. A petition for rehearing was denied on September 27, 1994. Pet. App. A67-A68. The petition for a writ of certiorari was filed on December 23, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

Petitioner St. Francis Medical Center is a provider of health care services covered under Part A of the Medicare Act, Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.* (Medicare Act). Pet. App. A23. Part A provides for the payment of insurance benefits for hospital and related post-hospital medical services. The present dispute arose from petitioner's contention that it has been improperly denied certain Medicare reimbursement payments.

1. The Medicare payments at issue here are made to providers under the cost-based reimbursement system set out by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, 96 Stat. 324 (codified, as amended, at 42 U.S.C. 1395ww(b)).[2] See also 42 U.S.C. 1395f(b) and (x)(v)(1)(A). Pet. App. A23. Under TEFRA, a provider may not receive more than the "target amount" of per patient costs that is calculated according to the provider's actual cost of service in the "base year" (which is the twelve-month reporting period

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[2] In 1983, Congress largely replaced the TEFRA cost-based system with the prospective payment system (PPS), but certain types of hospitals and hospital units are excluded from the PPS. See 42 U.S.C. 1395ww(b) and (d)(1)(A-B). Among the excluded units are distinct rehabilitation units. See 42 U.S.C. 1395ww(d)(1)(B); Pet. App. A6. This case involves such a unit.

immediately before the TEFRA effective date), adjusted in succeeding years by a specified percentage. 42 U.S.C. 1395ww(b)(3)(A); Pet. App. A3-A4. Providers also are eligible for "incentive payments" that reward a hospital for furnishing services to patients at a cost below its TEFRA target amount. Pet. App. A26. Those incentive payments are equal to one-half of the difference between the hospital's yearly costs and the target amount. 42 U.S.C. 1395ww(b); Pet. App. A23-A24.

2. Petitioner operates an acute-care hospital that includes a distinct part rehabilitation unit, and its costs for the unit are reimbursed through the TEFRA cost-reimbursement scheme. Pet. App. A6, A25. For purposes of determining TEFRA reimbursements and incentive payments, petitioner's base year was fiscal year 1985, which ended on June 30, 1985. *Id.* at A6. During fiscal year 1985, Blue Cross and Blue Shield of Western Pennsylvania (Blue Cross/Blue Shield), petitioner's fiscal intermediary,[3] determined that petitioner's rehabilitation unit did not qualify as a distinct part rehabilitation unit under the applicable regulations because less than 75% of the patients in the unit required intensive rehabilitation. *Id.* at A25. In an attempt to meet the 75% requirement for distinct part rehabilitation units, petitioner transferred some of its "non-qualifying" patients—those not requiring intensive rehabilitation—from the rehabilitation unit. *Id.* at A25. That transfer was not completed until June 30, 1986, a full year after the end of petitioner's base-year period. *Ibid.*

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[3] "Fiscal intermediaries" are private organizations that assist the Secretary of Health and Human Services in making Medicare payments and payment determinations. 42 U.S.C. 1395; 42 C.F.R. 421.103.

3. The dispute underlying petitioner's claim is based on petitioner's contention that because the patient transfer was completed after the end of the 1985 base year, some of the non-qualifying patients were included in the base-year cost calculation before they were transferred out of the rehabilitation unit. Pet. App. A6. That resulted, according to petitioner, in "average patient costs * * * higher in 1986 than the estimates of those costs derived from the 1985 base year cost report." *Ibid.*[4] Petitioner contended that the calculation of costs for the base year resulted in the wrongful withholding of almost $2,000,000 in payments for 1986 through 1988. *Id.* at A43.

In an attempt to obtain incentive payments, petitioner sought to adjust its base-year cost report pursuant to 42 C.F.R. 413.40(g) and (h). Pet. App. A7, A24. The Health Care Financing Administration (HCFA) denied petitioner's request for such an adjustment, holding that petitioner's transfer of nonqualifying patients out of the rehabilitation unit after the end of the base year did not constitute "an extraordinary circumstance beyond the hospital's control," which would have justified an adjustment. *Id.* at A7.

Petitioner appealed that decision of HCFA to the Provider Reimbursement Review Board (PRRB). The PRRB, citing 42 U.S.C. 1395*oo*(a) and 42 C.F.R. 405.1835, held that it lacked jurisdiction over petitioner's claim pertaining to fiscal year 1985, because petitioner's request for an adjustment of its base-year cost report did

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[4] In addition, petitioner argued that the base-year cost report erroneously omitted costs for an expansion of the hospital. Pet. App. A6.

not involve an amount in controversy of at least $10,000. Pet. App. A7.[5]

4. Petitioner then filed the present suit in the United States District Court for the Western District of Pennsylvania challenging the jurisdictional ruling by the PRRB. The district court remanded the case to the PRRB, holding that the PRRB had jurisdiction to hear petitioner's claim because it was required to consider the total amount of payments to which petitioner might be entitled between 1985 and 1988 when determining whether the amount in controversy with respect to petitioner's claim met the $10,000 requirement in 42 U.S.C. 1395*oo*(a). Pet. App. A52-A64.

5. The court of appeals reversed, holding that petitioner failed to meet the $10,000 amount-in-controversy requirement. Pet. App. A21-A38. The court noted (*id.* at A30) that 42 U.S.C. 1395*oo*(a)(1)(A)(i) states that the PRRB has jurisdiction over an appeal if the provider is dissatisfied with "the amount of total program reimbursement due to the provider for the items and services furnished to individuals for which payment may be made . . . *for the period covered by such report.*" Consequently, the court concluded that a single provider is not permitted under the applicable statutory provisions and regulations "to aggregate claims over several cost reports in order to satisfy the amount in controversy requirement." Pet. App. A29-A30.

Petitioner contended in the alternative on appeal that if the district court did not have jurisdiction under 42

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[5] However, the PRRB exercised jurisdiction over petitioner's claims for fiscal year 1986. Those claims were settled, resulting in a reimbursement of $1,117,355 to petitioner for full in-patient operating costs for fiscal years 1986 through 1988. Pet. App. A8 n.3.

U.S.C. 1395*oo*, it would have general federal question jurisdiction over the case under 28 U.S.C. 1331. Because that issue had not been raised or addressed below, the court of appeals remanded the case to the district court to afford petitioner the opportunity to amend its complaint to assert jurisdiction under 28 U.S.C. 1331. Pet. App. A33-A34.

6. On remand, petitioner filed a two-count amended complaint. In Count One, petitioner argued that the methodology used by HCFA in reviewing petitioner's application for a base-year adjustment constituted the imposition of an improper reimbursement ceiling. In Count Two, petitioner alleged a violation of its equal protection rights, claiming that it received unfair treatment as compared to providers whose base year cost reports were "undistorted." Pet. App. A10. The Secretary moved to dismiss the amended complaint, arguing that 42 U.S.C. 405(h), which states that no action may be brought to recover on any claim arising under the Social Security Act (of which the Medicare Act is a part) against the United States or any officer thereof under 28 U.S.C. 1331, precluded the exercise of jurisdiction by the district court. The district court granted the motion to dismiss. Pet. App. A39-A51. The court of appeals affirmed, holding that petitioner's claim arises under the Medicare Act and that 42 U.S.C. 405(h) therefore bars jurisdiction in the district court. Pet. App. A1-A20.

ARGUMENT

1. Petitioner first contends (Pet. 15-21) that the reimbursement amounts in years following 1985 that would be affected by the adjustment of its 1985 base-year costs may be combined to satisfy the $10,000 amount-in-controversy requirement for jurisdiction under 42

U.S.C. 1395*oo*. The court of appeals correctly rejected that contention in its first decision. Pet. App. A21-A38.

a. The jurisdiction of the PRRB and the district court to review a Medicare provider's claims in a reimbursement dispute is set out in 42 U.S.C. 1395*oo*. That Section states: "Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by [the PRRB]" if each of several preconditions set forth in 42 U.S.C. 1395*oo*(a)(1)-(3) is satisfied. 42 U.S.C. 1395*oo*(a). As relevant here, paragraph (1) of 42 U.S.C. 1395*oo*(a) states that review by the PRRB is available if the provider "is dissatisfied with the * * * amount of the total program reimbursement due to the provider for the items and services furnished to individuals for which payment may be made * * * for the period covered by such [cost] report." 42 U.S.C. 1395*oo*(a)(1)(A)(i). Paragraph (2) adds the further precondition that "the amount in controversy is $10,000 or more."

The text of these two paragraphs clearly defines the "amount in controversy" in terms of the "amount" of the reimbursement due for the period covered by the particular cost report in question. Nowhere does the Act state that an individual provider may combine the amounts in controversy in each of several distinct cost reporting periods to meet the jurisdictional conditions of 42 U.S.C. 1395*oo*(a). As the court of appeals noted, it is reasonable to assume that if Congress had intended to allow a single provider to aggregate claims over a number of years to provide the jurisdictional amount for a single year's claim, it would have so indicated. Pet. App. A30. That is especially so since 42 U.S.C. 1395*oo*(b) expressly allows another form of aggregation—the combination of the claims of several providers if the total

amount in controversy is $50,000 or more. "In the context of the statute's precisely drawn provisions," the omission of any provision for aggregation of the amounts at issue in different cost reports of a single provider indicates that Congress intended to foreclose that result. *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 (1982).

The legislative history of the Medicare Act supports the conclusion that Congress intended that only a single cost year be considered in assessing whether the $10,000 amount in controversy is satisfied. The House Report, addressing the creation of the PRRB and the amount-in-controversy requirement for single-provider appeals, states:

> Any provider of services which has filed a timely cost report may appeal an adverse final decision of the fiscal intermediary *with respect to the period covered by such a report* to the Board where the amount in controversy is $10,000 or more.

H.R. Rep. No. 231, 92d Cong., 1st Sess. 108 (emphasis added) (1971). Congress obviously contemplated that only a single cost reporting "period" would be considered in determining whether the amount-in-controversy requirement for PRRB jurisdiction is satisfied for a claim based on a single cost "report." *Ibid.*

The regulations promulgated to implement 42 U.S.C. 1395*oo* likewise limit the amount in controversy to claims involving the reporting period covered by the cost report at issue. See 42 C.F.R. 405.1801(a)(1) and (2). The Secretary has consistently followed those regulations in refusing to aggregate the amounts in dispute from multiple cost reports submitted by an individual provider in determining whether the amount-in-controversy requirement has been satisfied. See Pet. App. A32

(citing *Bradner Village* v. *Blue Cross & Blue Shield Ass'n/Blue Cross*, Medicare & Medicaid Guide (CCH) ¶ 38,428, at 22,412 (HCFA Adm'r Dec. Mar. 11, 1990); *Home Call, Inc.* v. *Blue Cross & Blue Shield Ass'n*, Medicare & Medicaid Guide (CCH) ¶ 36,261, at 13,862 (HCFA Adm'r Dec. Feb. 6, 1987)).

In this case, the amount of reimbursement petitioner seeks for base year 1985 is less than $10,000. Indeed, petitioner concedes (Pet. 15) that, absent the sums allegedly due for subsequent years, it does not meet the amount in controversy requirement for its base year claim. Because the statutory language, legislative history, and implementing regulations all indicate that the amount-in-controversy cannot be met by combining amounts of reimbursement allegedly due for several years, the court of appeals properly held that the PRRB (and therefore the district court) did not have jurisdiction under 42 U.S.C. 1395*oo* to entertain petitioner's challenge to the base-year reimbursement report.[6]

b. An additional reason that petitioner's contention must fail is that petitioner did not exhaust its

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[6] Petitioner errs in relying (Pet. 16-19) on the availability of judicial review of the revised base-year costs for graduate medical education expenses in *Methodist Hospitals* v. *Sullivan*, 799 F. Supp. 1210 (D.D.C 1992), rev'd on other grounds *sub nom. Administrators of Tulane Educational Fund* v. *Shalala*, 987 F.2d 790 (D.C. Cir. 1993), cert. denied, 114 S. Ct. 740 (1994). In that case, the provider's cost report for a post-base-year period was reopened pursuant to special statutory provisions, and the base-year costs were recalculated only for purposes of reviewing the reimbursable costs for the reopened cost year. The decision the latter cost report reopening was then appealable to the PRRB and the district in the same manner that an original decision on a cost report may be appealed. *Methodist Hospital* therefore lends no support to petitioner's contention that it may aggregate amounts-in-controversy for two or more different years.

administrative remedies for the years after 1985. The Social Security Act prescribes the exclusive procedures for judicial review of claims, and unless those procedures are followed, judicial review of benefit claims is unavailable. See 42 U.S.C. 405(h); *Heckler* v. *Ringer*, 466 U.S. 602, 606 (1984); *Weinberger* v. *Salfi*, 422 U.S. 749, 757 (1975).

Under the Social Security Act, to meet exhaustion requirements, a claimant must present its claim to the Secretary and exhaust all further applicable administrative remedies. *Ringer*, 466 U.S. at 606-607; *St. Francis Hosp.* v. *Bowen*, 802 F.2d 697, 701 (4th Cir. 1986); see also *Mathews* v. *Eldridge*, 424 U.S. 319, 328 (1976). In cases involving Medicare provider reimbursement disputes, 42 U.S.C. 1395*oo*(f)(1) requires a "final decision" of the Secretary regarding a provider's Medicare reimbursement claim for the specific fiscal year in dispute. A provider then must file separate appeals before the PRRB concerning each individual cost year for which it disputes the Secretary's payment determination. See *Abington Mem. Hosp.* v. *Heckler*, 750 F.2d 242, 244 (3d Cir. 1984) (district court's grant of relief limited to individual claims for reimbursement considered by PRRB), cert. denied, 474 U.S. 863 (1985); *Pacific Coast Medical Enters.* v. *Harris*, 633 F.2d 123, 137-139 (9th Cir. 1980) (court could only hear claim for year properly pending); *Riley Hosp. & Benevolent Ass'n* v. *Bowen*, 804 F.2d 302, 305-306 (5th Cir. 1986) (district court had jurisdiction only over cost reporting periods that had been conclusively ruled upon by PRRB); *Hospital Ass'n* v. *Secretary of Health & Human Servs.*, 820 F.2d 533, 539-540 (1st Cir. 1987) (court did not have jurisdiction to determine additional reimbursement for years beyond the year properly before it).

This case involves only petitioner's appeal to the PRRB with regard to its base year. Although petitioner also appealed to the PRRB with respect to fiscal year 1986, it subsequently settled its claims for the years 1986-1988. Because petitioner abandoned any right of further review, it did not exhaust its administrative remedies for those years. As a result, there was no final decision of the PRRB, other than that for 1985, when petitioner sought judicial review.

2. Petitioner also seeks review of the decision in *St. Francis II*, arguing that "the court of appeals departed from the accepted and usual course of judicial proceedings by affirming [a Rule 12 dismissal] notwithstanding the acknowledged existence of disputed questions of fact." Pet. 22. That claim lacks merit.

The Medicare Act, at 42 U.S.C. 1395ii, incorporates Section 205(h) of the Social Security Act, 42 U.S.C. 405(h). The third sentence of Section 405(h) provides: "No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter." As this Court has held, "the inquiry in determining whether § 405(h) bars federal-question jurisdiction must be whether the claim 'arises under' the Act." *Ringer*, 466 U.S. at 615. A claim "arises under" the Medicare Act when the Act furnishes "both the standing and the substantive basis for the presentation" of the claim. *Ibid.* (quoting *Salfi*, 422 U.S. at 760-761). Section 405(h) serves to foreclose federal question jurisdiction over both "substantive" and "procedural" claims, as well as for constitutional claims. *Ringer*, 466 U.S. at 615.

Petitioner's claim before the district court in *St. Francis II* unquestionably was a claim "arising under" the Medicare Act. Petitioner alleged that HCFA

imposed an improper ceiling on its Medicare reimbursement. In addition, petitioner sought a judgment directing the Secretary to make additional Medicare payments. Pet. App. A14; compare *Ringer*, 466 U.S. at 614-615.

Petitioner argues (Pet. 23) that the availability of administrative remedies under 42 U.S.C. 1395*oo* in this case presented a disputed question of fact that the district court should have resolved. Pet. 23. The asserted factual dispute, however, was irrelevant to the court of appeals' jurisdictional ruling.

Although the court of appeals acknowledged that petitioners allege that respondent made conflicting statements concerning administrative review, the court correctly concluded that the dispute did not affect the determination of the issue in the case, namely—the availability of jurisdiction for petitioner's claim under 28 U.S.C. 1331. Pet. App. A19.[7] The court explained that because the dispute focused on what the Secretary said about available remedies, and not about what remedies were actually available, the dispute was immaterial to the question of the district court's jurisdiction over petitioner's claim because "[s]ubject matter jurisdiction can never be created by estoppel." Pet. App. A9, citing *Rubin* v. *Buckman*, 727 F.2d 71, 72 (3d Cir. 1984).[8]

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[7] Although petitioner alleges that this aspect of the opinion "has so far departed from the accepted and usual course of proceedings" as to justify review by this court, Pet. 25-26, petitioner fails to dispute the court of appeals' conclusion that the dismissal of petitioner's claim was proper notwithstanding a dispute over an irrelevant factual assertion by petitioner.

[8] Petitioner asserts (Pet. 26) that "[t]he only other way to read *St. Francis II*" is to conclude that it conflicts with *Beverly Hospital* v. *Bowen*, 872 F.2d 483, 486 (D.C. Cir. 1989), creating a

3. Petitioner also contends (Pet. 27-29) that the court of appeals erred by failing to follow this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), which concluded that 42 U.S.C. 405(h) did not bar a district court from exercising jurisdiction under 28 U.S.C. 1331 over certain challenges to the administration of Part B of the Medicare program.[9] That contention is meritless.

This Court's ruling in *Michigan Academy* on the applicability of Section 405(h) pertained exclusively to Part B of the Medicare Act. See *Michigan Academy*, 476 U.S. at 680. This Court explicitly contrasted the methods of review in Part A and Part B under the particular statutory provision at issue in that case, 42 U.S.C. 1395ff, which governs the right of Medicare *beneficiaries* (and, under Part B, of the assignees of beneficiaries' claims) to seek judicial review. Section 1395ff provided for judicial review under Part A (subject to an amount-in-controversy requirement), but not under Part B. See 476 U.S. at 675-676. As the court of appeals noted, if this Court in *Michigan Academy* had held that general federal question jurisdiction was lacking, the complaining parties would have had no available avenue

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split in the circuits. Petitioner fails to explain that assertion or provide support for it.

[9] Petitioner suggests that the court of appeals declined to follow *Michigan Academy* on the ground the case is "no longer good law." Pet. 27. Although the court cited *National Kidney Patients Ass'n* v. *Sullivan*, 958 F.2d 1127, 1130 (D.C. Cir. 1992), cert. denied, 113 S. Ct. 966 (1993), which held that *Michigan Academy* was no longer authoritative in light of the 1986 Amendments affecting Medicare Part B, this case involves Part A of the Act.

for challenging the regulation at issue. Pet. App. A16-A17.[10]

After *Michigan Academy* was decided, Congress amended 42 U.S.C. 1395ff to provide for judicial review under part B, if amount-in-controversy requirements are met. See Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9341, 100 Stat. 2037 (codified at 42 U.S.C. 1395ff(b)(1)). Because challenges to regulations and methodologies for determining claims under Part B may be brought pursuant to 42 U.S.C. 1395ff, the courts of appeals have held that general federal question jurisdiction may no longer be invoked under the rationale of *Michigan Academy*, even with respect to Part B claims. See *Farkas* v. *Blue Cross & Blue Shield*, 24 F.3d 853, 860 (6th Cir. 1994); *Abbey* v. *Sullivan*, 978 F.2d 37 (2d Cir. 1992); *National Kidney Patients Ass'n* v. *Sullivan*, 958 F.2d 1127, 1130 (D.C. Cir. 1992), cert. denied, 113 S. Ct. 966 (1993). Petitioner acknowledges (Pet. 28) that the courts of appeals are uniform in their rulings on that point.

Moreover, the present case involves a dispute under Part A of the Medicare Act, which was not governed by *Michigan Academy* in the first place. Just as 42 U.S.C. 1395ff, as in effect at the time of *Michigan Academy*, furnished an avenue for judicial review of Part A beneficiary claims, 42 U.S.C. 1395*oo* now furnishes an avenue for judicial review of Part A provider claims. Thus, the court below correctly concluded:

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[10] Thus, in holding that Section 405(h) did not foreclose federal question jurisdiction over certain challenges under Part B, this Court's disposition avoided the "'serious constitutional question' that would arise if [it] construed [the Section] to deny a judicial forum for constitutional claims arising under Part B of the Medicare program." *Michigan Academy*, 476 U.S. at 681 n.12.

> Since a provider seeking Part A payments has * * * avenues of review available under the Medicare Act, the presumption that Congress did not intend to foreclose judicial review, which was central to the decision in *Michigan Academy*, is inapplicable. And in the absence of that presumption, we read 42 U.S.C. § 405(h), as incorporated into the Medicare Act * * *, to mean that [petitioner] may not assert its claim under 28 U.S.C. § 1331.

Pet. App. A17; accord *Westchester Management Corp.* v. *Department of Health & Human Servs.*, 948 F.2d 279, 282 (6th Cir. 1991), cert. denied, 112 S. Ct. 1936 (1992). The decision below therefore is fully consistent with *Michigan Academy*.

The issue petitioner seeks to raise is, in any event, of no continuing importance. As the court of appeals pointed out (Pet. App. A19), beginning in 1990, a provider may request a new base period that is more representative of the provider's reasonable and necessary costs. See 42 U.S.C. 1395ww(b)(4)(A) and (B) (Supp. V 1993). If the Secretary denies such a request, the provider may then challenge that denial before the PRRB (and, if necessary, the district court) in connection with a challenge under 42 U.S.C. 1395*oo* to the total amount of reimbursement paid for the particular cost period for which the provider contends the Secretary should have calculated its costs by reference to a new base year. That avenue is available to petitioner with respect to any future cost periods, as well as current or past cost periods since 1990 in which petitioner has preserved the issue. See Pet. App. A19-A20. There accordingly is no reason for this Court to grant review to consider petitioner's effort to fashion an alternative avenue of review in an independent suit under

28 U.S.C. 1331 to challenge the Secretary's decision concerning petitioner's 1985 cost year.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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FEBRUARY 1995